

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

12503

Reg. Dist. No. 3330

1. PLACE OF DEATH
County McCombs
City or town Parramatta
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
P.O. #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Ind. County McCombs
City or town Parramatta
(If outside city or town limits, write RURAL and give nearest town)
Street No. P.O. #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Bertha Arrey 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Walter Thomas Arrey

7. Birth date of deceased (mo., day, yr.) No Record - 1900 - 6. (c) If alive, give age 46 years

8. AGE: Years 46 Months — Days — If less than one day — hrs. — min. —

9. Birthplace Lucy C. Delaware
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business at home

12. Name George Butler

13. Birthplace Lucy C. Del.

14. Maiden name Maria Paine

15. Birthplace P.O. Parramatta Ind.

16. Informant Mr. Walter T. Arrey

Address P.O. #2 Parramatta Ind.

17. Burial, cremation, or removal, Which? Burial Date thereof Dec. 4-46
(month) (day) (year)

Cemetery or crematory Bethel Cem.

Location Walston Maryland

18. Funeral director Walter P. Holloway

Address Salisbury Maryland

19. Date rec'd by registrar 12/14/46 Registrar Harriet L. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1st 19 46 at 350p M

I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27 19 46 to Dec. 1 19 46
and that I last saw her alive on Nov. 29 19 46

Immediate cause of death CA of Pancreas

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William D. Gray, M.D.

Address Salisbury, Ind. Date signed 12/3/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
BUREAU OF
ARTESIAN LEADER
SAS CONTIN

RECEIVED
DEC 23 1946
BUREAU V &

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

Reg. Dist. No. 3930

1. PLACE OF DEATH:

County Quinn
City or town Salisbury md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Don't know

Hospital, institution, or street address where death occurred:

Penninsula General Hospital
How long in hospital or institution? about 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State NH County Wilcomet
City or town Salisbury md
(If outside city or town limits, write RURAL and give nearest town)Street No. Lake St
(If rural, give LOCATION)2.(a) If veteran, name war Don't know

3. (a) FULL NAME

Fred Lee Bell

3. (b) Social Security Number

Don't know

4. Sex

Male

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Caulbourne Bell
Don't know

7. Birth date of

deceased (mo., day, yr.)

May 20 1890
about 56 7 24 hrs. min.

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

Yemassee Georgia
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Same as above

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Welfare Office Wilcomet

Address

Salisbury md

17. Burial, cremation, or removal (Which?)

Public

Date thereof

Dec 16, 1946
(month) (day) (year)

Cemetery or crematory

Public

Location

Salisbury md

18. Funeral director

James P. Stewart

Address

Salisbury md

19. Date received by registrar

12/16, 1946

Registrar

James P. Stewart

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1946, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

medical examinationand that I last saw him alive on 19

Immediate cause of death

Gunshot wound ofabdomen

DURATION

sudden

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 12/14/46Where did injury occur? Salisbury Wilcomet md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeMeans of Injury Gunshot wound Injured at work? no

23. SIGNATURE

James P. Stewart

Address

Salisbury md

M.D. or other

Date signed 12/14/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12504

RECEIVED

JAN 2 1947

BUREAU 6

2-35

ARTHELAN RECORD

Dr. Mays.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

12505

Reg. Dist. No. 9890

1. PLACE OF DEATH:

County W. VirginiaCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula General HospitalHow long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County SussexCity or town Laurel R.F.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Boyce Mr. Emory M.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced6. (b) Name of husband or wife Laura L. Boyce6. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) 2-14-18878. AGE: Years 59 Months 10 Days 5 If less than one day _____ hrs. _____ min.9. Birthplace Sussex Co. Delaware
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business _____

12. Name Samuel Warren Boyce13. Birthplace Delaware14. Maiden name Bastha Dunn15. Birthplace Delaware16. Informant Alan D. BoyceAddress Laurel Del R.F.D.17. Burial Date thereof 12-21-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory 2007Location Laurel18. Funeral director Riggin & CooperAddress Laurel Del19. 18/81 19 46 Harriet S. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1946 at 2:25 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/19/46 to 12/19/46and that I last saw him alive on 12/19/46Immediate cause of death Diabetic Coma

DURATION

Due to Diabetic mellitus

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles M. MaysAddress Laurel Del Date signed 12/20/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1947

PERLAU F B.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

12506
Reg. Dist. No. 3330

1. PLACE OF DEATH
County... Salisbury
City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years
Hospital, institution, or street address where death occurred:
421, Marshall St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... MD County... Salisbury
City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 421, Marshall St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sallie Jane Boyman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife William J. Boyman
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) March 15 1872

8. AGE: Years 74 Months 8 Days 20 If less than one day hrs. min.

9. Birthplace Connet Co. Marie Md.
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business at home

12. Name William J. Boyman

13. Birthplace Marie Md.

14. Maiden name Sarah Jane Loken

15. Birthplace Connet Co. Md.

16. Informant M. Otis Boyman

Address 421, Marshall St. Salisbury Md.

17. Burial (Burial, cremation, or other) Dec. 8 1946
(month) (day) (year)

Cemetery or crematory Chole Cem.

Location Chole, Maryland

18. Funeral director Hillway & Co.

Address Salisbury Maryland

19. 12/8/46 19 46 Barrie J. Johnson
(Date rec'd by registrar) (M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5th 19 46 at 11:35 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 5 1946
and that I last saw him alive on 19

Immediate cause of death Cerebral Lymphoma DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Phyllis A. Fisher M. D. or other

Address Salisbury Md Date signed 12-7-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 24 1946
BUREAU

2-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-H

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH: *McComie*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
905 E. Church St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....*MD* County.....*McComie*
City or town.....*Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *905 E. Church St.*
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME *Russell Charles Brittingham* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
8. (b) Name of husband or wife *Charles Brittingham*
7. Birth date of deceased (mo., day, yr.) *July 20 - 1919* 8. (c) If alive, give age *26* years
8. AGE: Years *27* Months *4* Days *18* If less than one day
9. Birthplace *Salisbury Maryland*
(Town, county and state)
10. Usual occupation *Labourer*

11. Industry or business
12. Name *Fred Brittingham*
13. Birthplace *Sussex Co. Delaware*
14. Maiden name *Helen Billie*
15. Birthplace *Salisbury Maryland*
16. Informant *Mrs. Brittingham*
Address *112 East St. Delmar Del.*
17. Burial *Buried* Date thereof *Dec. 11 - 1946*
(Burial, cremation, or removal) Which (month) (day) (year)
Cemetery or crematory *M. E. Cemetery*
Location *Delmar Delaware*
18. Funeral director *Holloman & Co. Walter R. Holloman*
Address *Salisbury Maryland*
19. *12/11/46* 19. *H. E. Johnson*
(Date received by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH *Dec. 8th* 19 *46* at *9:55* p.m.
I CERTIFY that death occurred on the date above stated: that I attended deceased from
and that I last saw *deceased* alive on *Examined*
Immediate cause of death *Carbon monoxide poisoning* DURATION *sudden death*
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings of operations *None* Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.
21. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide *suicide* Date of *12/8/46*
Where did injury occur? *Salisbury* (City or town) *McComie* (County) *MD* (State)
Injured at home, farm, industry, public place (where?) *Home*
Means of Injury *Turned gas on* Injured at work? *No*
23. SIGNATURE *Deputy med Examr* M. D. or other
Address *Salisbury MD* Date signed *12/10/46*

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 1 1947

BUREAU 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No.

12508

3300

1. PLACE OF DEATH:

County... Hiconico
 City or town... Mardela Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md County... Itis
 City or town... Mardela
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

E. Addie Bonaway

3. (b) Social Security Number

4. Sex ♀ 5. Color or race N 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Rev Wm Bonaway
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) July 13- 1873
 8. AGE: Years 73 Months 4 Days 17 If less than one day hrs. min.

9. Birthplace Mardela Itis Md.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business
 12. Name James H. Eversam
 13. Birthplace Md
 14. Maiden name Eliza A. Floyd
 15. Birthplace Md

16. Informant Miss Edith J. Eversam
 Address Mardela, Md.
 17. Burial Date thereof 12-3-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mardela, Md
 Location "

18. Funeral director Appveyor Bros
 Address Sharptown, Md.

19. 12/5/46 19 W. H. Robertson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 19 46 at 9-30 P.M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 1946 to December 2, 1946
 and that I last saw him alive on December 2, 1946

Immediate cause of death Solar thrombosis
 DURATION 7 days

Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE William Eversich
Helen - Md. M. D. Doctor
 Address..... Date signed Dec. 3-46

RECEIVED

DEC 9 1946

BUREAU V B

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No.

12509 3370

1. PLACE OF DEATH:

County Wilcomica
 City or town White Haven Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wilcomica
 City or town White Haven Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Earnest Francis Conway

3. (b) Social Security Number

no

4. Sex

male

5. Color or race

a. a

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Arvilla Conway

7. Birth date of deceased (mo., day, yr.)

yes

8. (c) If alive, give age

about 1874

8. AGE:

Years

Months

Days

If less than one day

about 72

9. Birthplace

White Haven Md
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

Same as above

MOTHER FATHER

12. Name

Jango Conway

13. Birthplace

White Haven Md

14. Maiden name

May H. Bates

15. Birthplace

White Haven Md

16. Informant

Mrs. Miriam White

Address

Salisbury Md

17.

burial

Date thereof

Dec. 8 - 46
(month) (day) (year)

Cemetery or crematory

family

Location

White Haven Md

18. Funeral director

James Stewart

Address

Salisbury Md

19.

79

19

46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 6 1946 at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1946 to Dec. 2 1946and that I last saw him live on Dec. 2 1946

Immediate cause of death

uremia

DURATION

Due to

Chronic Glomerulonephritis

Due to

arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

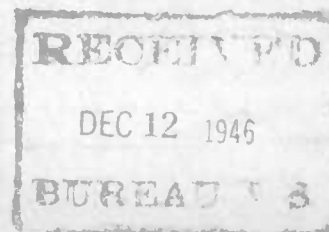
23. SIGNATURE

E. Purnell M.D.

M. D. or other

Address 800 W. Main St Salisbury Md signed 2/9/46

County
COPY SENT TO LOCAL REGISTRAR No. DATE 12-12-46



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-1

CERTIFICATE OF DEATH

 12514 3990
 Reg. Dist. No.

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 hrs. - 15 mins
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 27 hrs. - 15 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Delaware County Sussex
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Dashields John Dashields

3. (b) Social Security Number

4. Sex male 5. Color or race Col 6.(a) Single, married, widowed, or divorced widower
 6.(b) Name of husband or wife Annie Dashields

7. Birth date of deceased (mo., day, yr.) do not know 1882 6.(c) If alive, give age 85 years

8. AGE: Years about 54 Months - Days - If less than one day - hrs. - min.

9. Birthplace Ind
 (Town, county, and state)

10. Usual occupation Salisbury

11. Industry or business

12. Name Shirley Dashields

13. Birthplace Ind

14. Maiden name Silby Price

15. Birthplace Ind

16. Informant Shirley Dashields

Address Laurel Del

17. Burial Date thereof 12-19-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lewis Cemetery

Location Laurel

18. Funeral director Beggs & Cooper

Address Laurel Del

19. 12/19/46 Registrar Charles E. Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 19 46, at 6:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16 19 46 to Dec 17 19 46
 and that I last saw him alive on Dec. 17 19 46

Immediate cause of death Congestive Heart Failure
Syphilis of Heart and Aorta

Due to Tertiary syphilis

Other conditions Uremia +

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

David J. Levine M.D.

23. SIGNATURE _____ M. D. or other

Address 301 N. Division St. Date signed Dec 17, 1946

Salisbury, Ind.

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

JAN 4 1947

BUREAU OF INVESTIGATION

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (118)

CERTIFICATE OF DEATH

Reg. Dist. No. 3930

1. PLACE OF DEATH:

County..... Wicomico
City or town..... Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 40 Years
Hospital, institution, or street address where death occurred:
213 Snow Hill Road
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Wicomico
City or town..... Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 213 Snow Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

Clifford H. Duffy

3.(b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
6.(b) Name of husband or wife..... Thelma C. Duffy
6.(c) If alive, give age..... 38 years
7. Birth date of deceased (mo., day, yr.)..... Feb. 20, 1906.
8. AGE: Years..... 40 Months..... 10 Days..... 6 (if less than one day)..... hrs. min.

9. Birthplace..... Salisbury, Wicomico Co. Maryland.
(Town, county, and state)

10. Usual occupation..... Cab. operator, Insurance

11. Industry or business..... Broker, General.

12. Name..... Ralph C. Duffy

13. Birthplace..... Salisbury, Md.

14. Maiden name..... Nancy J. Chatham

15. Birthplace..... Worcester, Co. Md.

16. Informant..... Mrs. Clifford H. Duffy

Address..... Salisbury, Md.

17. Burial..... Date thereof..... 12/29/46
(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Wicomico memorial Park

Location..... Salisbury, Md.

18. Funeral director..... The Hill & Johnson Co.

Address..... Salisbury, Md.

19. 1/3..... 47.....
(Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 26, 1946..... 19..... a 11 P...... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from.....
Medical Examination Report..... 19.....
and that I last saw him alive on..... 12/26..... 19..... 46

Immediate cause of death.....

Sudden Hemorrhage

DURATION

sudden

Due to..... Acute Sepsis

2 weeks

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Thomas J. Fisher, M.D.

Address..... Salisbury, Md. Date signed..... 12/27/46

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 7 1947

BURIA

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12512

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital
7300ms.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Wicomico

City or town Waterview
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Evans Mr. Charles

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1878

8. AGE: Years 68 Months 2 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Waterview, Wicomico, Md.
 (Town, county, and state)

10. Usual occupation Postmaster

11. Industry or business _____

12. Name Robert E. Evans13. Birthplace Waterview, Md.14. Maiden name Sally Bradshaw15. Birthplace Waterview, Md.16. Informant Annah Collier SmithAddress Ohio Ave. Salisbury, Md.

17. Burial Date thereof 1 3 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sumner CemeteryLocation Panthers, Md.18. Funeral director C. E. MessickAddress Buwalde, Md.

19. 1/8 1947 Harriet E. Johnson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-31 1946, to 12-31 1946

and that I last saw him alive on 12-31-46 1946

Immediate cause of death Cerebral hemorrhage

DURATION

Due to Hypertension

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Cerebral hemorrhage, massive, rt.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William H. Fisher Jr. M.D.

M. D. or other

Address Peninsula Gen HospitalDate signed 1-1-47Salisbury, Md.

RECEIVED
JAN 7 1947
BUREAU OF

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1330

12513

CERTIFICATE OF DEATH

Reg. Diat. No. 7330

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days - 16 hrs. 30 min.
 Hospital, institution, or street address where death occurred:
Penninsula General Hospital
 How long in hospital or institution? 6 days 16 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Virginia County Accomack
 City or town Chincoteague
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

FITCHETT, Juanita

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife none
 7. Birth date of deceased (mo., day, yr.) October 17 1930 6.(c) If alive, give age _____ years
 8. AGE: Years 16 Months 2 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Chincoteague va
 (Town, county, and state)

10. Usual occupation none

11. Industry or business _____

12. Name Judson Fitchett

13. Birthplace Chincoteague va

14. Maiden name Helene Birch

15. Birthplace Chincoteague va

16. Informant Mrs Helene Fitchett

Address Chincoteague va

17. Buried Date thereof Dec 27 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory mechanics

Location Chincoteague va

18. Funeral director Walter M. Clark

Address Chincoteague va

19. 12/87 19 46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 December 1946 at 8:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 December 1946 to 24 December 1946
 and that I last saw him alive on 24 December 1946

Immediate cause of death Acute pyelonephritis
 DURATION 3 weeks

Due to _____

Due to _____

Other conditions Cerebral paralysis 104.6
Malnutrition 3 weeks
 (Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Arthur M. D.

Address 221 1/2 Camden Ave. M. D. or other _____

Date signed 25 Dec. 46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1947

BUREAU V S.

2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH



12514

Reg. Dist. No. 8390

1. PLACE OF DEATH

County Talbot
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years
 Hospital, institution or street address where death occurred: Hammond street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Talbot
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hammond street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Eva Jane Greenblade

3. (b) Social Security Number

4. Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced MarriedB. (b) Name of husband or wife George Alfred Greenblade7. Birth date of deceased (mo., day, yr.) March 9th 1882 B. (c) If alive, give age 82 years8. AGE: Years 64 Months 11 Days 11 If less than one day _____ hrs. _____ min.9. Birthplace Panama, C.A.
(Town, county, and state)10. Usual occupation Home mkr11. Industry or business Robert St. Home12. Name Joseph Green13. Birthplace France14. Maiden name Josephine Green15. Birthplace France16. Informant M. Robert GreenbladeAddress Hammond st. Salisbury Md17. Burial (Burial, cremation, or removal, which?) Buried Date thereof Dec. 24, 1946Cemetery or crematory W.C. Mum. Park Cem.Location Salisbury Maryland18. Funeral director Hoffman & C. Walter R. HoffmanAddress Salisbury Maryland19. Date rec'd by registrar 12/21/46 Registrar W. H. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20th 1946 at 8 P. M.I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to Dec 20 1946and that I last saw him alive on Dec 20 1946Immediate cause of death Pulmonary Tuberculosis - DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Phyllis L. Johnson M. D. or otherAddress Salisbury, Md Date signed 12-21-46

RECEIVED

JAN 4 1947

BUREAU OF THE

2-35

W. Robinson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170-2

12515

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County W. Somerset
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 4 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)
State MD County W. Somerset
City or town Parsonage, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Handy, James

3. (b) Social Security Number

4. Sex male 5. Color or race C 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary Handy

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1922 8. (c) If alive, give age _____ years

8. AGE: Years 24 Months 0 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Princeton, Somerset, Md.
(Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business _____

12. Name Car Handy

13. Birthplace Wintersburg, Md.

14. Maiden name Lucilia Handy

15. Birthplace Wintersburg, Md.

16. Informant Mary Handy

Address Parsonage, Md

17. (Burial, cremation, or removal, which?) Burial Date thereof Dec. 4, 1946
(Month) (day) (year)

Cemetery or crematory John Wesley Cemetery

Location Princess Anne, Md

18. Funeral director David H. Presick

Address Salisbury, Md

19. 12/4/46 19 46 Carroll E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st 19 46 at 5:28 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased for _____ days, _____ weeks, _____ months, _____ years, and that I last saw medical certificate alive on _____ 19 _____

Immediate cause of death Fracture Skull
Fractured mandible

DURATION

3 hours

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

Antopsy results as above Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12/1/46

Where did injury occur? Salisbury (City or town) W. Somerset (County) State (State)

Injured at home, farm, industry, public place (where?) Public street

Means of injury Two cars collided Injured at work? No

Signature Dr. Rademacher MD M. D. or other _____

Address Salisbury, Md Date signed 12/1/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 AT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 23 1946

BUREAU 7 &

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12516

Reg. Dist. No. 3380

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days - 19 hrs
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Delaware County Sussex
 City or town Rural - Millsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Hearne Liana Jane

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 7. Birth date of 12-9-40 6.(c) If alive, give age _____ years
 deceased (mo., day, yr.) 12-12-46
 8. AGE: Years _____ Months _____ Days _____ If less than one day
3 days _____ hrs. _____ min.
 9. Birthplace Salisbury, Wicomico, Md.
 (Town, county, and state)
 10. Usual occupation _____

11. Industry or business

MOTHER FATHER
 12. Name Norris Hearne
 13. Birthplace Delmar, Del.
 14. Maiden name Alma Parker
 15. Birthplace Millsboro

16. Informant Norris Hearne
 Address Millsboro

17. Burial Date thereof 12/13/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Harney's Cemetery
 Location near Millsboro, Del.
Harney Hickman

18. Funeral director Millsboro, Del.
 Address _____

19. 12/13 19 46 Harriet E. Johnson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 19 46 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12-9-46 19 46 to Dec. 12 19 46

and that I last saw her alive on 12-12-46 19 46

Immediate cause of death Intercranial Hemorrhage

Due to Birth injury

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. V. Wood M. D. or other _____

Address _____ Date signed _____

RECEIVED

JAN 2 1947

BUREAU 78

2-35

ANTHONY LONGER

RAG CONTENT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12517

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4
Hospital, institution, or street address where death occurred:
204 4th St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 204 4th Street.
(If rural, give LOCATION)
2. (a) If veteran, name war —

3. (a) FULL NAME

James Clarence Holden

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married.

6. (b) Name of husband or wife Allice Holden

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 8th 1910

8. AGE: Years 36. Months 8 Days 23 If less than one day — hrs. — min.

9. Birthplace Onancock Va.
(Town, county, and state)
Butler.

10. Usual occupation none

11. Industry or business none

12. Name Alton Holden

13. Birthplace Onancock Va

14. Maiden name Erna Custus

15. Birthplace Onancock, Va

16. Informant Allice C. Holden

Address 204 4th St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 5 1947
(month) (day) (year)

Cemetery or crematory Onancock Va

Location Onancock cem.

18. Funeral director Daguer M. Lusk

Address 464 Lake St.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1946 at 9:03 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-29 1946 to 12-31 1946

and that I last saw him alive on December 31 1946

Immediate cause of death Cerebral Apoplexy

Due to Hypertension

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. A. Purperry, M.D.

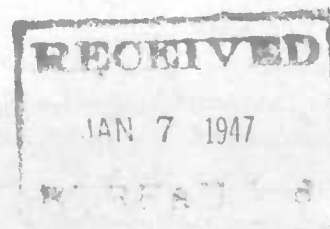
Address 800 N. Main St. Stuyvesant Date signed 1-1-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County WicomicoVillage or City Salisbury, MarylandNo. 605 SmithRegistration Dist. No. 9890

St., Ward

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME

Lizzie Bailey Howard(a) Residence: No. Hebron, Maryland Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (write the word) <u>Widowed</u>
-------------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day, and year) July 27, 1865

7. AGE <u>81</u>	Years	Months <u>4</u>	Days <u>27</u>	If LESS than 1 day, ----- hrs. or ----- min.
---------------------	-------	--------------------	-------------------	--

OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Housewife</u>
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.
	10. Data deceased last worked at this occupation (month end year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Wicomico County
(State or country)

FATHER	13. NAME <u>Theodore Bailey</u>
	14. BIRTHPLACE (city or town) <u>Wicomico County</u> (State or country) <u>Maryland</u>

MOTHER	15. MAIDEN NAME <u>Elizabeth Bennett</u>
	16. BIRTHPLACE (city or town) <u>Wicomico County</u> (State or country) <u>Maryland</u>

17. INFORMANT Dalton B. Howard
(Address)18. BURIAL, CREMATION, OR REMOVAL
Place Hebron, Md. Date Dec. 27, 194619. UNDERTAKER M. Pasha, Watson & Co.
(Address) Salisbury, Md.20. FILED 12/27, 1946 Charles E. Johnson
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

December 24, 1946
(Month) (Day) (Year)22. I HEREBY CERTIFY. That I attended deceased from
Dec. 24, 1946, to Dec. 24, 1946I last saw him alive on Dec. 24, 1946, death is said
to have occurred on the date stated above, at 10:40 P.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Coronary artery disease

Date of onset

1930

Other Contributory Causes of importance:

Arteriosclerosis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) Robert R. Starr M. D.
(Address) 500 N. Division, Salisbury

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

12519

Reg. Dist. No. 2930

1. PLACE OF DEATH
County... McCombs
City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or special address where death occurred:
300 N. College Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Md. County... McCombs
City or town... Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Louisa Emily Howard 3. (b) Social Security Number _____

4. Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife Samuel R. Howard
7. Birth date of deceased (mo., day, yr.) Aug. 18-1865 6. (c) If alive, give age Dec 4 years
8. AGE: Years 81 Months 3 Days 25 It less than one day _____ hrs. _____ min.

9. Birthplace R.D. Mardela Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business At Home

12. Name William Jackson

13. Birthplace Dorchester Co. Md.

14. Maiden name Louisa Bradley

15. Birthplace Dorchester Co. Md.

16. Informant Mrs. Olive Banks

Address 300 N. College Ave. Salisbury Md.

17. Burial (Burial, cremation, or removal) Buried Date thereof Dec. 15-1946
(month) (day) (year)

Cemetery or crematory Hebron Cem.

Location Hebron Maryland

18. Funeral director Holloway & Co. Walter R. Holling

Address Salisbury Maryland.

19. 12/15/46 19 46 Registrar Charles R. Mann

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec. 13 46 19 46 at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 36 to Dec 13 19 46
and that I last saw him alive on Dec. 8 19 46

Immediate cause of death Coronary Thrombosis DURATION 1 hr.

Due to Valvular Heart Disease 10 yrs

Due to Myocardium 10 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles R. Mann M. D. or other _____

Address Salisbury Md. Date signed 12/14/46

RECEIVED

JAN 2 1947

BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

Reg. Dist. No. 12571-3330

1. PLACE OF DEATH:

County Wilcombe
 City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Wilcombe
 City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
 Street No. West (If rural, give LOCATION)
 2. (a) If veteran, name war of World War 1917-18

3. (a) FULL NAME

Levin S. Hudson

3. (b) Social Security Number

4. Sex male 5. Color or race W. C. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Elcie Hudson 7. Birth date of deceased (mo., day, yr.) July 5 - 1921

8. AGE: Years 25 Months 6 Days 6 It less than one day no hrs. min.

9. Birthplace Salisbury (Town, county, and state)

10. Usual occupation State Roads Commission

11. Industry or business Same as above

12. Name Levin S. Hudson

13. Birthplace Salisbury MD

14. Maiden name Ann Parsons

15. Birthplace Salisbury MD

16. Informant Levin S. Hudson

Address Salisbury MD

17. Burial, cremation, or removal. Which? Burial Date thereof Dec. 15 - 1946 (month) (day) (year)

Cemetery or crematory Hawston

Location Salisbury MD

18. Funeral director Jane H. Stewart

Address Salisbury MD

19. 12/15 1946 Registrar Harriet E. Johnson

(Date rec'd. by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1946 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiner 1946 and that I last saw him alive on December 11, 1946

Immediate cause of death stab wound of heart DURATION sudden

Due to Homocide

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antepoxy results stab wound of heart

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homocide Date of 12/11/46

Where did injury occur? Salisbury Wilcombe MD (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

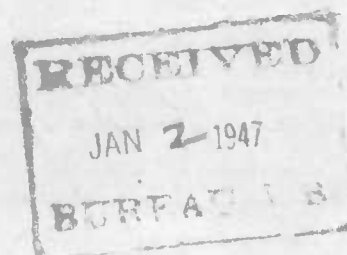
Means of injury stab wound of heart Injured at work? no

23. SIGNATURE Levin S. Hudson M. D. or other

Address Salisbury MD Date signed 12/12/46

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF PLANT INDUSTRIES



2-35

Cambridge

ARTESIAN LEADS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

CERTIFICATE OF DEATH

Reg. Dist. No.

12520
3630

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hughes, Mr. Charles

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Mrs. Hughes

7. Birth date of deceased (mo., day, yr.) December 8, 1876 6.(c) If alive, give age _____ years

8. AGE: Years 70 Months 1 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Salisbury, Wicomico, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Steam Mill

12. Name John Hughes

13. Birthplace Salisbury, Md.

14. Maiden name Unknown

15. Birthplace _____

16. Informant Mrs. Mary Wright

Address Shoptown, Md.

17. Burial Date thereof Dec. 31, 1946
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Salisbury, Md.

Location Salisbury Cemetery

18. Funeral director David K. Meserich

Address Salisbury, Maryland

19. 12/31/46 19 46 Salisbury, Md.
(Date recd by registrar) (year) (month) (day) (place)

MEDICAL CERTIFICATION

20. DATE OF DEATH December, 28, 1946, at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Dec 28, 1946

and that I last saw him alive on Dec 28, 1946

Immediate cause of death _____ DURATION _____

Hypertensive heart disease acute

Due to Ch. Myocarditis acute

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Hypertensive heart disease Date of op. 12/24/46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Dr. H. H. H. M. D. or other _____

Address Salisbury Date signed 12/30/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

FILED IN STATIONERY

APPELLATE LEADER

RAG CONTENT

RECEIVED

JAN 7 1947

BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

12521

Reg. Dist. No. 2330

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

General Hospital

How long in hospital or institution?

3 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 405 1/2 E. 1st St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jenkins, Mr. Frank

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Alvie M. Jenkins

7. Birth date of

deceased (mo., day, yr.)

8. (c) If alive, give age ✓ years

8. AGE:

Years

Months

Days

If less than one day

95

hrs.

min.

9. Birthplace

unk

(Town, county, and state)

10. Usual occupation

unk

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof Dec. 18, 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

19. 46

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1946 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 8, 1946 to Dec. 16, 1946and that I last saw him alive on Dec. 16, 1946

Immediate cause of death

Cerebro-vascular Accident

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Charles W. Trader

M. D. or other

Address Salisbury, Md.Date signed Dec. 16, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15731

STATE OF TEXAS

RECEIVED
JAN 4 1947
BUREAU V B.

2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

12522

Reg. Dist. No. 3387

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 11/26/46
 Hospital, institution, or street address where death occurred:
Eastern Shore Tb. Sanatorium
Salisbury, Md.
 How long in hospital or institution? Since 11/26/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 226 E. Locust St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Johnson, James, Markel

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Hannah E. Johnson
 6.(c) If alive, give age 71 years
 7. Birth date of deceased (mo., day, yr.) June 27, 1876
 8. AGE: Years 70 Months 5 Days 4 If less than one day
 hrs. min.

9. Birthplace Wicomico County, Maryland
 (Town, county, and state)
 10. Usual occupation Janitor
 11. Industry or business

FATHER 12. Name James J. Johnson
 13. Birthplace Maryland Wicomico Co.
 MOTHER 14. Maiden name Emma Parsons
 15. Birthplace Maryland Wicomico Co.

16. Informant Mrs. Hannah E. Johnson
 Address 226 E. Locust St. Salisbury Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 3-46
 (month) (day) (year)
 Cemetery or crematorium Wicomico Mem. Park
 Location Salisbury Maryland

18. Funeral director Hellmayer Co. Walter R. Hellmayer
 Address Salisbury Maryland

19. 12/3/46 (Date rec'd by registrar) Registrar Paul

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 19 46 at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 26 19 46, to Dec 1 19 46
 and that I last saw him alive on Dec. Nov. 30 19 46

Immediate cause of death Pulmonary Tuberculosis DURATION 2 month

Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Paul M. D. or other
 Address Snow Hill, Md. Date signed 12/2/46

RECEIVED

DEC 23 1946

BUREAU V S.

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 64

CERTIFICATE OF DEATH

Reg. Dist. No. 3930

1. PLACE OF DEATH:

County Wagoner
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 hours
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 20 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Westover
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Louise Margaux Maddox
4. Sex Female 5. Color or race C. 6.(a) Single, married, widowed, or divorced _____

3. (b) Social Security Number

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) November 25, 1946 6.(c) If alive, give age _____ years

8. AGE: Years _____ Months 10 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Westover, Maryland
(Town, county, and state)

10. Usual occupation _____

11. Industry or business

12. Name John Maddox
13. Birthplace Jamestown, Maryland
14. Maiden name Cecie Sheffield
15. Birthplace Tazley, Virginia

16. Informant John Maddox
Address Westover, Maryland

17. Burial, cremation, or removal, which? Burial Date thereof 12/17/46
(month) (day) (year)

Cemetery or crematory Manokin Glen

Location Manokin, Md.

18. Funeral director John Maddox
Address Westover, Md.

19. 12/17 19 46 Barrie L. Brown
(Date rec'd by registrar) (Year) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1946 at 1 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____
and that I last saw him/her alive on _____ 19____
Immediate cause of death Status Lymphaticus

Due to Enlarged Thyroid

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results Enlarged Thyroid, collapsed lungs
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Rademacher MD
Deputy Med Examiner
M. D. or other _____

Address Salisbury, Md. Date signed 12/6/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 24 1946
BUREAU V 8

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1540

CERTIFICATE OF DEATH

Reg. Dist. No. 12524 8930

1. PLACE OF DEATH

County WorcesterCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Newark
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mason, Mrs Julia Anne

3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife John L. Mason7. Birth date of deceased (mo., day, yr.) June 29, 1874

6. (c) If alive, give age _____ years

8. AGE: Years 72 Months 5 Days 19 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Maryland13. Birthplace Maryland14. Maiden name Harnett E. Richardson15. Birthplace Maryland16. Informant Mr. Ralph MasonAddress Newark Md.17. Buried Date thereof 12/20/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory M. E. CemeteryLocation Summit Hill Md18. Funeral director James A. BurroughsAddress Berlin Md19. 12/20, 46 Harnett E. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1946 at 2:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 1946 to Dec 18 1946and that I last saw her alive on Dec 18 1946Immediate cause of death Acute Myocardial Infarction

DURATION

Due to _____

Due to _____

Other conditions Chronic Fibrous Pericarditis

(Include pregnancy within 3 months of death)

Major findings of operations None at PericarditisDate of op. Dec 19/46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. H. Hub M. D. or otherAddress Salisbury Date signed 12/16/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1947

BUREAU V B

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

12525

1. PLACE OF DEATH:

Codily..... Wicomico
 City or town..... Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Since 11/16/46
 Hospital, institution, or street address where death occurred:
Eastern Shore Tb. Sanatorium
 How long in hospital or institution?..... Since 11/16/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Caroline
 City or town..... Rt 2, Federalsburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Rt. #2
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

Nichols, Anna Elizabeth

3. (b) Social Security Number

220-01-9648

4. Sex..... Female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Paul Nichols
 6. (c) If alive, give age..... 40 years

7. Birth date of deceased (mo., day, yr.)..... Sept. 28, 1907
 8. AGE: Years..... 39 Months..... 2 Days..... 17 If less than one day..... hrs. min.

9. Birthplace..... Riverside, New Jersey
 (Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business..... 4

FATHER 12. Name..... Thomas Henry Stockley

13. Birthplace..... Denver, Colorado

MOTHER 14. Maiden name..... Mary Dockerty

15. Birthplace..... Maryland

16. Informant..... self

Address.....

17. Burial Date thereof..... 12-18-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Coyne Cemetery

Location..... Coyne, Md.

18. Funeral director..... Harvey Williams

Address..... Federalsburg, Md.

19. 12/18/46 Registrar..... Barrie D. Phelan
 (Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 15, 1946, at 9:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 16, 1946, to Dec. 15, 1946
 and that I last saw her alive on Dec. 14, 1946

Immediate cause of death..... Carcinoma of liver DURATION..... 1 mo.

Due to..... Carcinoma with abdomen

Due to..... original lesion not located..... unknown

Other conditions..... Rheumatism, Car. di. with Auricular fibrillation unknown
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Paul Chen M.D. M. D. or other

Address..... Snow Hill, Md. Date signed..... 12/16/46

RECEIVED

JAN 4 1947

BUREAU V C

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

Reg. Dist. No. 12526-3930

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Heelma
(If outside city or town limits, write RURAL and give nearest town)
Street No. R 704 3
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Sallie Sarena Nichols

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mr. J. Nichols

7. Birth date of deceased (mo., day, yr.) Dec 24-1888 8. (c) If alive, give age 61 years

8. AGE: Years 58 Months 7 Days 7 If less than one day hrs. min.

9. Birthplace Wicomico County, Md.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business Home

12. Name Jas. D. Nichols

13. Birthplace Wicomico County, Md.

14. Maiden name Mary Ellen Apsey

15. Birthplace Wicomico County, Md.

16. Informant Mr. J. Nichols

Address Heelma, Md.

17. Burial Buried Date thereof Jan 2-1947
(Burial, cremation, or removal, with?) (month) (day) (year)

Cemetery or crematory Nichols

Location Heelma, Md.

18. Funeral director W. S. Grand Co

Address Heelma, Md.

19. 1/3 19 47 Harris & Johnson
(Date rec'd by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 19 46, at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 46, to Dec 31 19 46

and that I last saw him alive on Dec 30 19 46

Immediate cause of death Respiratory failure DURATION 3 days

Due to Emphysema of lungs 13m

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Signature J. H. Lynch M. D. or other

Address Heelma, Md. Date signed Dec 31/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 7 1947

RECEIVED

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 1252330

1. PLACE OF DEATH:

Coumty Wicomico
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 days
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Wicomico
 City or town Pontiloke md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

John W. Butler

3. (b) Social Security Number

no

4. Sex

male

5. Color or race

a a

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mrs. Mahle R. Butler

7. Birth date of deceased (mo., day, yr.)

Nov 27, 1864

6. (c) If alive, give age years

Don't know

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>0</u>	<u>4</u>	hrs. min.

9. Birthplace

Pontiloke md
(Town, county, and state)

10. Usual occupation

Operator and Farmer

11. Industry or business

Farmer

FATHER

12. Name

George Butler

13. Birthplace

Pontiloke md

14. Maiden name

Sarah Clay

15. Birthplace

Pontiloke md

16. Informant

Mrs. Mahle Butler

Address

Pontiloke md

17. Burial

Burial

Date thereof

Dec 4-46
(month) (day) (year)

Cemetery or crematory

Pontiloke

Location

Pontiloke md

18. Funeral director

James M. Stewart

Address

Salisbury md

19. Date rec'd by registrar

12/4/46

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 1, 1946 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 16, 1946 to December 1, 1946and that I last saw him alive on Dec 1, 1946

Immediate cause of death

Coronary Occlusion
arteriosclerosis

DURATION

(?)

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

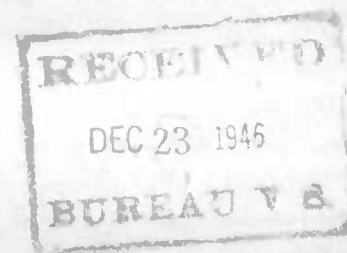
Means of injury Injured at work?

23. SIGNATURE

John H. Yeaman
332 Camden Ave
Salisbury, Md.

M. D. or other

Date signed



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

 12528
 Reg. Dist. No. 3330

1. PLACE OF DEATH: *ViComile*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution or street address where death occurred:
P.B. Hosp.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For new born infants give residence of mother)
Ind. ViComile
 State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *R.O. #3.* *(Delmar Road)*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced
 6. (b) Name of husband or wife *Hettie Oliphant*
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr) *Oct. 29 - 1879*

8. AGE: Years *67* Months *1* Days *28* If less than one day
 hrs. min.

9. Birthplace *Dorchester Co. Md.*
 (Town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business

12. Name *Hettie Oliphant*

13. Birthplace *Sussex Co. Delaware*

14. Maiden name *Mary Lank*

15. Birthplace *P.O. Delmar, Delaware*

16. Informant *Mr. George Oliphant*

Address *P.O. # 3. (Delmar Rd.) Salisbury Md.*

17. Burial (Burial, cremation, or funeral. Which?) *Burial* Date thereof *Dec. 30 - 46*
 (month) (day) (year)

Cemetery or crematory *Parsons Cem.*

Location *Salisbury Maryland*

18. Funeral director *Holloman & Mallett R. Holloman*

Address *Salisbury Maryland*

19. *12/30/46* Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 27* 19 *46* at *11:00 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *December 26* 19 *46* to *Dec 27* 19 *46* and that I last saw him alive on *Dec. 27* 19 *46*

Immediate cause of death..... DURATION

Tobacco pneumonia

Due to.....

Due to.....

Other conditions *Pleurisy*

(Include pregnancy within 9 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *H. V. Bohler, M.D.* D. or other

Address *Delmar, Md.* Date signed *12-28-46*

RECEIVED

JAN 4 1947

BUREAU OF

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

12529
Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 90 Years
 Hospital, institution, or street address where death occurred:
106 W. London Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 106 W. London Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Ellen Parker

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife George E. S. Parker
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct. 10, 1855
 8. AGE: Years 91 Months 1 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Wicomico Co. Maryland
 (Town, county, and state)
 10. Usual occupation at home

11. Industry or business

12. Name Thomas J. Calloway
 13. Birthplace Wicomico Co. Maryland.
 14. Maiden name Amy P. Wilson
 15. Birthplace Sussex Co. Del.

16. Informant Mrs. W. T. Chipman
 Address Harrington. Del.

17. Burial Burial Date thereof 12/3/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Parsons Cemetery
 Location Salisbury, Md.

18. Funeral director The Hill & Johnson Co.
 Address Salisbury, Md.

19. 12/3/46 Registrar Harrington, Del.
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1946 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 Dec 1 to 26 Nov 30
 and that I last saw him alive on Nov. 30

Immediate cause of death Septicemia DURATION 3 days

Due to Pneumonia Internal
of 15 yrs

Due to Valvular Heart Disease 20 yrs
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Shirley R Mann M. D. or other _____
 Address Salisbury Md Date signed 12/1/46

MARGIN RESERVED FOR BINDING

VS-A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 23 1946

BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

12530
Reg. Dist. No. 8330

1. PLACE OF DEATH
County McComie
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
P.O. Box 261
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County McComie
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. P.O. Box 261
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Lee Peterson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
B. (b) Name of husband or wife Rene May Peterson
7. Birth date of deceased (mo., day, yr.) Oct. 19th 1891 6. (c) If alive, give age 41 years
8. AGE: Years 55 Months 1 Days 23 If less than one day
hrs. min.

9. Birthplace Sweden
(Town, county, and state)
10. Usual occupation Lumber Mill
11. Industry or business Lumber Mill
12. Name John Peterson
13. Birthplace Sweden
14. Maiden name Alma
15. Birthplace Sweden

16. Informant Mrs. Rene M. Peterson
Address P.O. Box 261, Salishon Md.
17. Burial or cremation (Burial, cremation, or removal of which?) Buried Date thereof Oct. 14-1946
(month) (day)
Cemetery or crematory Harmon Cemetery
Location Salisbury Maryland
18. Funeral director William R. Zillman
Address Salisbury Maryland

19. 13/1/46 19 46 Registrar Harriet E. Johnson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12th 1946 at 4 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 to Dec 12 1946
and that I last saw him alive on Dec 12 1946
Immediate cause of death Cancer of stomach with metastases to liver
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Stomach Date of op. Dec 1, 1946
Autopsy results Stomach
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of Dec 12, 1946
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE J. M. Webb M. D. or other
Address Salisbury Date signed 12/15/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 2 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

12531

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County..... Wicomico
 City or town..... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? I day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Wicomico
 City or town..... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
Rural 2
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... single
 6. (b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... Nov. 6, 1873 8. (c) If alive, give age..... years
 8. AGE: Years..... 73 Months..... I Days..... I If less than one day..... hrs. min.

9. Birthplace..... Wicomico Co., Maryland.
 (Town, county, and state)
 10. Usual occupation..... At Home
 11. Industry or business.....
 12. Name..... Levin Irving Pollitt
 13. Birthplace..... Wicomico Co., Maryland.
 14. Maiden name..... Ann Maria Ralph
 15. Birthplace..... Sussex Co. Del.

16. Informant..... W. Ralph Pollitt
 Address..... Salisbury, Maryland. R. D. 2
 17. Burial..... Date thereof..... Dec. 9, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Parsons Cemetery
 Location..... Salisbury, Maryland.
 18. Funeral director..... The Hill & Johnson Co.
 Address..... Salisbury, Maryland.

19. 12/9 19 46 Levin I. Pollitt
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

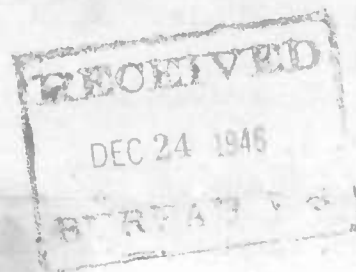
20. DATE OF DEATH..... Dec. 7, 1946 19..... at 2:10 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 19 46 to Dec 7 19 46
 and that I last saw her alive on Dec 7 19 46
 Immediate cause of death..... Coronary Thrombosis 4 days
 Due to..... Arterio-sclerosis
 Due to..... Valvular Heart Disease
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... Levin R. Mann
 Address..... Salisbury, Md.
 M. D. or other.....
 Date signed..... 12/8/46



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

12532

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Rural Snow Hill Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Powell, Master Orville

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 2, 19328. AGE: Years 14 Months 9 Days 24 If less than one day _____ hrs. _____ min.9. Birthplace Pocomoke Wicomico, Md.
(Town, county, and state)10. Usual occupation School boy

11. Industry or business _____

12. Name Elton Powell13. Birthplace Maryland14. Maiden name Etta Ella Truel15. Birthplace Maryland16. Informant Mr. Elton PowellAddress Rural Snow Hill Md.17. Burial Date thereof Dec 31-1946
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematorium Salem M. E. CemeteryLocation Pocomoke Md.18. Funeral director Glenn E. WatsonAddress Pocomoke City Md.19. 13/31 19 46 Registrar Carroll E. Johnson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 19 46 at 10 ³⁰ P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14 19 46 to Dec 28 19 46 and that I last saw him alive on Dec 28 19 46

Immediate cause of death _____ DURATION

Acute Appendicitis lessAcute Caecal Fecal half

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. 12/24/46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE _____ M. D. or other

Address Belmont Inn Date signed 12/30/46

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

ATTORNEY GENERAL

WASHINGTON, D. C.

RECEIVED

ARTERIAL LESION

NO. 1000000000

RECEIVED
JAN 7 1947
PENNA

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 67

12533

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County WorcesterCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 hours

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 32 hrs. 12 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural # 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Marian Purcell

3. (b) Social Security Number

4. Sex Female 5. Color or race C. 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 19468. AGE: Years Months Days 1 less than one day min.9. Birthplace Berlin md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Purcell Everett13. Birthplace Berlin md14. Maiden name Duffy Hazel15. Birthplace Salisbury md16. Informant Bertha DuffyAddress Berlin, Md.17. Burial Date thereof 12/19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Family CemeteryLocation Snow Hill, Md.18. Funeral director Bertha DuffyAddress Berlin, Md.19. 12/19/46 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1946 at 6:17 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 18.

and that I last saw him alive on 19.

Immediate cause of death

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William H. Johnson M. D. or otherAddress Gen. Hosp. Date signed 12/17/46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 2 1947
BUREAU

2-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 60

CERTIFICATE OF DEATH

12534
Reg. Dist. No. 2330

1. PLACE OF DEATH:

County..... *Wicomico*
City or town..... *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *8 days*
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? *8 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... *MD.* County..... *Wicomico*
City or town..... *Middle Springs*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Edward Rowley

3. (b) Social Security Number

4. Sex..... *Male* 5. Color or race..... *White* 6. (a) Single, married, widowed, or divorced..... *Married*
6. (b) Name of husband or wife..... *Catherine Rowley*
6. (c) If alive, give age..... *55* years
7. Birth date of deceased (mo., day, yr.)..... *Aug. 27, 1889.*
8. AGE: Years..... *57* Months..... *3* Days..... *12* If less than one day..... hrs. min.

9. Birthplace..... *Burton, England*
(Town, county, and state)
10. Usual occupation..... *Artist*
11. Industry or business..... *Commercial*
12. Name..... *William Rowley*
13. Birthplace..... *England*
14. Maiden name..... *Ada Louise Barrett*
15. Birthplace..... *India*

16. Informant..... *Mrs. Edward Rowley*
Address..... *Middle Springs, Md.*
17. *Cremation* Date thereof..... *12/10/46*
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... *Frederick Park*
Location..... *Baltimore, Md.*
18. Funeral director..... *Re. Hill & John Co.*
Address..... *Salisbury, Md.*
19. *125 / 9* 19 *46* *Harriet E. Johnson*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Dec. 9* 19 *46* at *8:50 A.M.*
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Nov 50* 19 *46* to *Dec 9* 19 *46* and that I last saw him alive on..... 19.....

Immediate cause of death.....

Myocardial infarction

Due to.....

Myocardial infarction

Major findings of operation.....

Date of op. *Dec. 1, 1946*

Autopsy results..... *None*
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....
Where did injury occur?.....
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of Injury..... Injured at work?.....

23. SIGNATURE

Thos. W. S.
M. D. or other
Date signed.....

RECEIVED
DEC 24 1946
BUREAU 78

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12535

Reg. Diat. No. 9930

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 weeks
 Hospital, institution, or street address where death occurred:
105 Chesapeake Salisbury Md
 How long in hospital or institution? med

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Salisbury Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 105 Chesapeake St. Salisbury
 (If rural, give LOCATION)
 2(a) if veteran, name war 40

3. (a) FULL NAME

John W. Tull
 4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced (C)

3. (b) Social Security Number

None

6. (b) Name of husband or wife Deed
 7. Birth date of deceased (mo., day, yr.) Jan. 15 - 1903 6. (c) If alive, give age 84 years

8. AGE: Years 73 Months 11 Days 1 If less than one day
 hrs. min.

9. Birthplace Stratton, Wicomico, Md
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name William Tull

13. Birthplace Maryland

14. Maiden name Martha Tull

15. Birthplace Maryland

16. Informant Mr. Charles Tull

Address 5037 Bathurst St. N.W. Pa.

17. Cause of death Bruise Date thereof Dec 19 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Protestant

Location Chapman St. Md

18. Funeral director Gray & Symms

Address Snook Hill, Md

19. 12/19/46 19 46 Barrie E. Johnson
 (Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16, 1946 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 6th 19 46 to Dec 16 19 46
 and that I last saw him alive on Dec 16 19 46

Immediate cause of death Stroke of Paralysis DURATION

Due to Haemorrhage

Due to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Causes of injury injured at work?

23. SIGNATURE Carrie E. Johnson M. D. or other

Address 2034 Church St. Salisbury Md Date signed

RECEIVED

JAN 4 1947

BUREAU V B.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12536

Reg. Dist. No. 3530

1. PLACE OF DEATH:

County Wilcomino
 City or town Salisbury, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Twelve
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Wilcomino
 City or town Salisbury, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 300 Lake
 (If rural, give LOCATION)
 2.(a) If veteran, name war md.

3. (a) FULL NAME

3. (b) Social Security Number

Armeda Harris Underwood

217-12-4890

4. Sex 5. Color or race 6. Single, married, widowed, or divorced

female a.g. married

6. (b) Name of husband or wife James Underwood

yes 8. (c) If alive, give age about 32 years

7. Birth date of deceased (mo., day, yr.) May 25 1922

8. AGE: Years Months Days If less than one day

24 hrs. min.

9. Birthplace Bridgeville, Del.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name Robert Harris

13. Birthplace Boston, Mass.

14. Maiden name Berlella Cannon

15. Birthplace Bridgeville, Del.

16. Informant Robert Harris

Address Salisbury, Md.

17. Burial, cremation, or removal (which?) Date thereof Oct 17 1946

(month) (day) (year)

Cemetery or crematory Houston

Location Salisbury, Md.

18. Funeral director James H. Stewart

Address Salisbury, Md.

19. 12/17/46 Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1946 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw deceased

Immediate cause of death

Pneumonia Tbc

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Rademacher

M. D. or other

Address Salisbury, Md.

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 1 1947

RECEIVED

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9930

1. PLACE OF DEATH:

County Wicomico Co
 City or town Salisbury Rural
 (If outside city or town limits write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County Wicomico
 City or town Salisbury MD
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Victor

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Col. single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1946

8. AGE: Years Months Days If less than one day

0 0 7 hrs. min.

9. Birthplace Salisbury MD
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name Robert Halland13. Birthplace Girdletruss MD14. Maiden name Hermion Victor15. Birthplace Snow Hill16. Informant Marion VictorAddress Salisbury MD17. Burial Date thereof 12/24/46
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory PublicLocation Salisbury18. Funeral director Booker M. WestAddress Salisbury MD19. 12/24/46 Date rec'd by registrar Barrett L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 19 46 at 7 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 18, 1946 to Dec. 24, 1946 and that I last saw him alive on Dec 20, 1946

Immediate cause of death

Pneumonia - Broncho-PneumoniaDue to BronchitisDue to Exacerbation of
attending with 12/18/46Other conditions (no pre-natal care)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

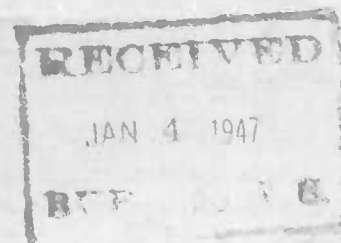
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

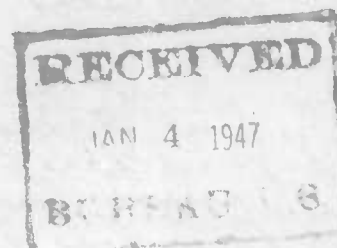
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Y. A. Sembly, M.D. M. D. or otherAddress Salisbury MD Date signed 12/24/46



2-35



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

12539

★ Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Salisbury
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
P.O. #1. on S. Division St. Eft.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)
 State Md. County Salisbury
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. P.O. #1. S. Division St. Eft.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William Henry Wetzel

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife Catherine Ann Wetzel

7. Birth date of deceased (mo., day, yr.) Nov. 11th 1872 8. (a) If alive, give age 69 years

8. AGE: Years 74 Months 0 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
 (Town, county, and state)

10. Usual occupation Home Painter

11. Industry or business

12. Name Samuel Wetzel

13. Birthplace Washington, D.C.

14. Maiden name Thompson

15. Birthplace

16. Informant Mrs. Catherine Ann Wetzel

Address P.O. #1. Salisbury Maryland

17. Burial, cremation, or removal, (Which?) Buried Date thereof Dec. 12-1946

Cemetery or crematory Waco. Mem. Park

Location Salisbury Maryland

18. Funeral director Walter R. Williams

Address Salisbury Maryland

19. 12/12 19. 46 Registrar Walter R. Williams

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10th 19 46 at 6:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 to Dec 9

and that I last saw him alive on Dec 9

Immediate cause of death Depress from infected DURATION 2 mos

Bladder due to Hypertension

Due to _____

Due to _____

Other conditions Hypertension urinary

Bladder Heat Given urinary

(Include pregnancy within 8 months of death)

Major findings of operations _____

Antemortem _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

Signature Walter R. Williams M. D. or other _____

Address Salisbury Md Date signed 12/11/46

RECEIVED

JAN 2 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

12540

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 hours
 Hospital, institution, or street address where death occurred:
South Division St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. D. I Snow Hill Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John M. Whayland

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Mary L. Whayland
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 30, 1874.
 8. AGE: Years 72 Months 6 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Allen, Wicomico Co. Maryland.
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

MOTHER FATHER
 12. Name Thomas J. Whayland
 13. Birthplace Wicomico Co. Maryland.
 14. Maiden name Sarah P. Ackworth
 15. Birthplace Wicomico Co. Maryland.

16. Informant William P. WhaylandAddress Salisbury, Maryland. R. D. I17. Burial Date thereof 12/24/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allen CemeteryLocation Allen. Maryland.18. Funeral director The Hill & Johnson Co.Address Salisbury, Maryland.19. 1/3 19 47 Thos. Hill & Johnson
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1946 19_____, at 430 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____
 and that I last saw him _____ alive on _____ 19_____
 Immediate cause of death Proxymy occlusion

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thos. Hill & Johnson M. D. or other _____Address Salisbury, Md Date signed 12/23/46

DURATION

Sudden death

RECEIVED

JAN 7 1947

RECEIVED 3

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

12541

Reg. Dist. No. 3270

1. PLACE OF DEATH:

County Wicomico
 City or town Birch
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Birch
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. P.O. Box Birch Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

George William Washington Willing

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Margaret Ellen Willing

7. Birth date of deceased (mo., day, yr.) March 19, 1865 6. (c) If alive, give age Dead years

8. AGE: Years 81 Months 8 Days 28 If less than one day
 hrs. min.

9. Birthplace Birch Maryland
 (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Farmer

12. Name James Willing

13. Birthplace Birch Md.

14. Maiden name Susan Insley

15. Birthplace Birch Md.

16. Informant Miss Margaret E. Willing

Address Birch Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 12/19/46
 (month) (day) (year)

Cemetery or crematory Birch Mt. Church Cemetery

Location Birch Md.

19. Funeral director Glenn Messick

Address Birch Md.

19. Dec 22 1946 P. Doolford Waller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17th 1946 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1946 to December 15 1946

and that I last saw him alive on December 15 1946

Immediate cause of death Cerebral hemorrhage DURATION ?

Due to Atherosclerosis ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

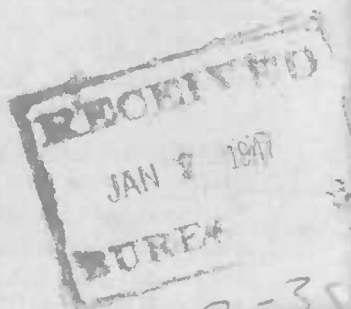
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. Doolford Waller M. D. or other

Address Wentzville, Md. Date signed 12-22-46



2-35